DISTRICT OF COLUMBIA
OFFICE OF ADMINISTRATIVE HEARINGS
825 North Capitol Street, NE, Suite 4150
Washington, DC 20002-4210

IN RE: KERNIE ROBIN Petitioner	Case No.: DH-B-08-800050

FINAL ORDER

I. Introduction

By letter dated January 17, 2008, (the "Notice") the Department of Health ("DOH") served Petitioner, Kernie Robin, with notice of its intent to list her in the Nurse Aide Abuse Registry (the "Registry"), maintained pursuant to 29 District of Columbia Municipal Regulations ("DCMR") 3251 and 3252.[1] The Notice alleges that on September 10, 2007, the Petitioner engaged in two acts of abuse or neglect of a resident (the "Resident")[2] at The Specialty Hospital of Washington / Hadley Hospital and Skilled Nursing Facility ("Hadley"). Specifically, DOH alleges that the Petitioner improperly manipulated the Resident's wheelchair causing him to fall out and that she also verbally abused the Resident.

[1] Under federal law a State participating in Medicare must maintain a nurse aide registry that includes information on any findings of abuse, neglect or misappropriation of funds by a nurse aide. 42 U.S.C. 1396r(g)(1)(C) and 42 C.F.R. §§ 400.203 and 483.156;

[2] Pursuant to 29 DCMR 3252.13, residents shall not be identified by name in this decision in order to ensure resident confidentiality.

The Notice informed Ms. Robin of her right to challenge the proposed listing by requesting a hearing before this administrative court within 20 calendar days of her receipt of the notice. On January 24, 2008, Petitioner filed a Request for Hearing pursuant to 29 DCMR 3253 to challenge the proposed listing of her name in the Registry.[3]

Pursuant to DOH's Motion and with Petitioner's consent I scheduled an evidentiary hearing for April 11, 2008. Carmen Johnson Esq., appeared on DOH's behalf and Mary Sklencar, a DOH Nurse Consultant, testified regarding her investigation of the September 10th incident. John Davis, a Hadley Security Officer, also testified. Petitioner appeared and testified on her own behalf.

Based upon the testimony in the record, my evaluation of the credibility of the witnesses and the documents admitted into evidence, I now make the following findings of fact and conclusions of law. Pursuant to 29 DCMR 3253.5, this decision is being issued within thirty days of the close of the record.

I. Findings of Fact

A. Credibility Analysis

The Petitioner concedes that the Resident fell from his electric wheelchair when she attempted to move him. The critical, contested issue is whether the Petitioner or the Resident operated the control lever that caused him to lurch forward in the chair and ultimately fall to the ground. The answer to this question bears directly on DOH's contention that the Petitioner was

[3] The regulations originally granted authority over the Nurse Aide Registry to the Department of Consumer and Regulatory Affairs. That authority has been transferred to the Department of Health, pursuant to Reorganization Plan No. 4 of 1996, Mayor's Order No. 97-42, and Mayor's Order No. 99-68. This administrative court has jurisdiction over this case pursuant to D.C. Official Code § 2-1831.03(a)(1).

neglectful in caring for a nursing home resident. The Petitioner asserts that the Resident pushed the control lever forward while she was attempting to reposition him in the chair. Ms. Sklencar testified, based upon her interviews with the Resident and four other residents who witnessed the incident, that the Resident fell when the Petitioner pushed the lever.

Although Ms. Skenclar's testimony was hearsay, in OAH proceedings all relevant evidence, including hearsay, is admissible. OAH Rule 2820.1. While not binding with respect to admissibility, the Federal Rules of Evidence provide "persuasive authority" in determining the weight to be accorded such evidence. OAH Rule 2820.2. Moreover, in determining the weight to be given hearsay evidence, this administrative court must consider that the actual witnesses who made the out of court statements were not subject to cross examination. See *Glenbrook Rd. Ass'n v. District of Columbia Bd. of Zoning Adjustment*, 605 A.2d 22, 39 (D.C. 1992) (quoting *Nat'l Trailer Convoy, Inc. v. United States*, 293 F. Supp. 634, 636 (N.D. Okla. 1968) (holding "in all adjudicative proceedings, 'cross-examination and confrontation are the handmaidens of trustworthiness in the face of factual dispute.'"). In this case the Petitioner's hearsay must also be measured against the Petitioner's sworn and cross-examined testimony which she presented during the hearing. *Compton v. D.C. Bd. of Psychology*, 858 A.2d 470 (D.C. 2004). In weighing the hearsay evidence, testimony and evidence tending to corroborate the hearsay must also be considered. *Gropp v. District of Columbia Board of Dentistry*, 606 A.2d 1010, 1014 (D.C. 1992).

In addition to Ms. Skenclar's testimony, DOH offered the Petitioner's written statement (DOH Exhibit 103) and Ms. Skenclar's testimony regarding her interview with the Petitioner.[4]

[4] Although these statements were made out of court they are admissions by a party and therefore not hearsay. Fed Rule Evid. R 801(d)(2).

In her written statement, prepared shortly after the September 10th incident, the Petitioner indicated that the Resident fell when she "tried to turn the chair towards the building door." In her interview, conducted by Ms. Skenclar on September 21, 2007, the Petitioner stated, "I moved the chair and [the Resident] fell to his knees." Neither statement suggests that the Resident operated the control lever or that he caused the fall. Given this glaring omission from Petitioner's own statements, I do not find her claim that the Resident pushed the lever to be credible. Moreover, I find that these statements tend to corroborate the Petitioner's hearsay evidence that the Resident fell out of the chair when the Petitioner moved the chair by pushing the lever forward.

The parties also disagreed on whether the Petitioner spoke to the Resident in a loud and angry manner and whether she accused him of being drunk. The Petitioner contends that although the Resident cursed her, she did not speak loudly and merely told him that she was tired and could not lift him in the chair. The Resident, and three of the four other residents interviewed by Ms. Sklencar, stated that during the incident the Petitioner spoke to the Resident in a loud and angry manner and accused him of being drunk. The fourth resident indicated that the Petitioner spoke to him "really nasty." Officer Davis's testimony at the hearing corroborated these hearsay statements. On this issue, I found the residents' statements and Officer Davis's testimony to be more credible than that of the Petitioner.

B. Findings

Based upon this analysis of the witnesses' credibility, I make the following findings:

Petitioner became a certified nurse aid ("CNA") in August 2006 and began her employment with Hadley in January 2007. In order to acquire her CNA certification, Petitioner received training in, among other things, the transfer, positioning and movement of patients who use wheelchairs. Hadley admitted the Resident, who was not ambulatory, to its nursing facility in February 2007. In addition to a number of illnesses, the Resident suffered from alcoholism. While at Hadley, the staff often found him intoxicated.[5] DOH Exhibit 101 (Investigative Report).

During her tenure at Hadley, the Petitioner frequently assisted the Resident in transferring to and from his electric wheelchair. The chair itself was equipped with a control lever that afforded the Resident mobility once he was properly positioned in his chair.

On September 10, 2007, the Resident was in his wheelchair outside the Hadley facility. Approximately four other residents were within 10 to 15 feet of the Resident. A visitor, who had passed the Resident before entering the hospital, encountered Officer Davis and advised him that one of the residents needed help. The Officer stepped outside and observed that the Resident was slouched in his chair and needed to be repositioned. He then telephoned the residents' nursing unit and requested assistance.

The Petitioner received Officer Davis' call and left the nursing unit to assist the Resident. When the Petitioner reached him, the Resident cursed her. In the presence of Officer Davis and four other residents, the Petitioner accused the Resident, in a loud, angry voice, of being drunk. After Officer Davis returned to the hospital, the Petitioner placed one hand on the Resident's chest and at the same time moved the control lever on his chair. The chair moved forward and the Resident fell to the ground. The Petitioner then went inside the hospital and asked Officer

[5] The Resident died on October 30, 2007, from causes unrelated to the events described in this decision.

Davis for assistance. He contacted the Petitioner's Supervisor, who, along with the Officer, succeeded in returning the Resident to his wheelchair.

The Resident alleged that he sustained scratches and bruises from this fall and Hadley's Director of Nursing observed scratches on the Resident's left rib cage after the incident. Because the Petitioner had a history of frequent falls, it is not certain whether these scratches were caused by his September 10th fall from the wheelchair.

II. Conclusions of Law

Pursuant to 29 DCMR 3252.7(d), a nurse aide must be listed in the Abuse Section of the Nurse Aide Registry if he or she "knowingly abused or neglected a resident." 42 CFR § 483.13 (c) (1) states in part:

> (1) The facility must --
>
> (i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion . . . .

The DCMR defines "abuse" as "the infliction of physical or mental harm on a nursing home resident," and "neglect" as a failure "to carry out or perform, or to be remiss in the care for or treatment of[,] a nursing home resident." 29 DCMR 3299.1.

Ms. Sklencar conceded that her investigation did not establish that the Petitioner knowingly abused the Resident in connection with his fall from the wheelchair. Instead, she contended that the Petitioner neglected the Resident when she moved the control lever and propelled the Resident's chair forward before he was safely positioned. As noted above, the regulations require listing any nurse aide who "knowingly abused or neglected a resident" in the

Registry. 29 DCMR 3252.7(d). DOH's argument thus implicitly raises an issue of statutory construction regarding whether the term "knowingly" is intended to modify both the term "abused" and "neglected", thereby requiring DOH to prove that the Petitioner knowingly neglected the Resident.

The "primary and general rule of statutory construction is that the intent of the lawmaker is to be found in the language that he has used." *Peoples Drug Stores v. District of Columbia*, 470 A.2d 751, 754 (D.C. 1983) (*en banc*). The court must first look to the plain meaning of the statute, construing words, "according to their ordinary sense and with the meaning commonly attributed to them." *Davis v. United States,* 397 A.2d 951, 956 (D.C. 1979). "The literal words of [a] statute, however, are not the sole index to legislative intent, but rather, are to be read in the light of the statute taken as a whole, and are to be given a sensible construction …." *District of Columbia v. Gallagher*, 734 A.2d 1087, 1091 (D.C. 1999) [quoting *Metzler v. Edwards*, 53 A.2d 42, 44 (D.C. 1947)]. Courts generally construe administrative regulations by the same rules that apply to the interpretation of statutes. *In re R.F.H.,* 354 A.2d 844, 845 n.2 (D.C. 1976); *KCMC Inc. v. FCC,* 600 F.2d 546, 549 (5th Cir. 1979); *Rucker v. Wabash R.R.,* 418 F.2d 146, 149 (7th Cir. 1969); C. Sands, SUTHERLAND, STATUTORY CONSTRUCTION § 31.06 (4th ed.

Whether the term "knowingly" is intended to modify "neglect" as well as "abuse" must be considered in the context of the Regulation's definitions. The term "neglect" is defined to include being remiss in the care of a nursing home resident. 29 DCMR 3299.1. The ordinary meaning of the term remiss is to be careless or showing inattention. *Merriam-Webster's Collegiate Dictionary* 719 (10th ed. 1993). To apply "knowing" as a modifier of "neglect" in this context would create a contradiction in terms. Instead, a logical construction requires DOH to establish that the Petitioner either knowingly abused a resident or acted carelessly regarding a

resident's care. This construction is consistent with the federal law that 29 DCMR 3252.7(d) is designed to implement. In requiring States to establish a nurse aide registry, the governing federal statute requires that if a State finds that a nurse aide has neglected *or* abused a nursing home resident, it must notify the Registry of such finding. 42 U.S.C. 1396r(g)(1)(C). Significantly, a State may not make a finding that an individual neglected a resident if the individual demonstrates that such neglect was caused by factors beyond his or her control. *Id.* Knowing neglect is not mentioned in the statute. *See also* 42 C.F.R. § 483.13 (c) (1) (ii) (B) "facility must . . . not employ individuals who have . . . had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property"). To read 29 DCMR 3252.7(d) consistently with federal law, a finding of neglect is sufficient to trigger notification to the Registry. Knowing neglect is not required.

Here, the evidence established that the Petitioner received training in the transfer, positioning and movement of patients who use wheelchairs and had frequently assisted the Resident in transferring to and from his electric wheelchair. The Petitioner testified that on September 10, 2007, when she attempted to reposition the Resident she was tired. To witnesses of the incident, she appeared to be angry. Whether due to fatigue or anger or other reasons, the Petitioner did not properly position the Resident in his wheelchair before she moved the control lever. In so doing, she disregarded her training. As a result, the Resident fell from the chair to the ground. Although the Petitioner appears to have acted carelessly rather than intentionally, she was nonetheless remiss in the care of a nursing home patient within the meaning of 29 DCMR 3299.1. Further, the Petitioner has not demonstrated that her neglect was caused by factors beyond her control. 42 U.S.C. 1396r(g)(1)(C).

The DOH's second basis for listing the Petitioner in the Registry is that she verbally abused the Resident by loudly accusing him of being drunk in front of other residents. The Court considered a similar claim of abuse in *Hearns v. DCRA*, 704 A.2d 1181 (D.C. 1997). In this case, a nurse aide pulled a resident by the arm from the corridor to his room and shook her finger in the resident's face in a reprimanding manner. There was no evidence of physical harm to the resident; however the Court found it was rationale to determine that the aide's actions caused the resident mental anguish. As a result, the Court affirmed a finding that the aide "intentionally 'inflicted . . . intimidation' upon the resident" and that this constituted mental abuse under 29 DCMR 3252.7(d).

Here, the Petitioner, in the presence of Officer Davis and four other residents accused the Resident, in a loud, angry voice, of being drunk. The Government did not present proof that the resident thereby suffered "physical harm [or] pain,"; however it is reasonable to conclude that accusing a person of being drunk it front of his peers would cause embarrassment, humiliation and "mental anguish." *Hearns*, 704 A.2d 1181, 1183 (noting that the position of nurse aide is one of trust and that the definition of "abuse" in the context of this relationship "may fairly be understood to reach behavior short of more flagrant forms dealt with in other settings.") On this basis I conclude that Petitioner verbally abused the Resident within the meaning of 29 DCMR 3252.7(d).

III. Order

Based upon my findings of fact and conclusions of law, it is, this _____ day of _____, 2008:

ORDERED, that the decision of the Department of Health to list Petitioner Kerne Robin in the Abuse Section of the Nurse Aide Registry is **AFFIRMED**; and it is further

ORDERED, that, pursuant to 29 DCMR 3252.11, the Department of Health shall record Petitioner's name in the Abuse Section of the Nurse Aide Registry along with the documentation required by that section; and it is further

ORDERED, that, pursuant to 29 DCMR 3252.12, the Department of Health shall circulate a copy of this Order to all nursing home administrators in the District of Columbia; and it is further

ORDERED, that the appeal rights of any person aggrieved by this Order are stated below.

April 29, 2008

_/s/_____
Louis Burnett
Administrative Law Judge